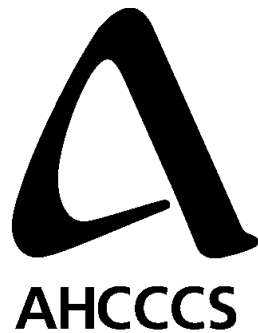


## **Chapter 27**

# **Understanding the Remittance Advice**



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## **GENERAL INFORMATION**

The *AHCCCS Fee-for-Service Remittance Advice* provides information about claims adjudicated by AHCCCS Fee for Service, including claims paid or voided and claims which were denied. The Remittance Advice is generated weekly. Paper Remittance Advice is mailed to the billing provider. If the billing provider has submitted claims for multiple service providers, the Remittance Advice will contain a section for each. This chapter primarily addresses the Paper Remittance Advice only, for information related to the HIPAA-compliant 835 transaction, please consult the Implementation Guide and/or Companion Document for the 835 transaction available on the AHCCCS Web site at [www.ahcccs.state.az.us](http://www.ahcccs.state.az.us).

## **835 REMITTANCE ADVICE**

Please note that the AHCCCS Companion Document is intended to supplement, but not replace, the Implementation Guide for the 835 transaction.

Providers who have completed the necessary registration and testing processes may download a HIPAA-compliant 835 electronic remittance advice for paid and denied claims from a secure AHCCCS Internet Web site and store the remittance in either electronic or hardcopy format on their internal systems.

To create an account and begin using AHCCCS Online, go to the AHCCCS Home Page at [www.ahcccs.state.az.us](http://www.ahcccs.state.az.us). Click on the Information for Providers link to go to the Providers page. A link on the Providers page allows providers to create a free AHCCCS Online account.

After creating an account, providers must download the trading partner agreement (TPA) and the Electronic Remittance Advice Manual. The TPA once completed, must be submitted to the AHCCCS Electronic Claims Submission (ECS) Unit. The ECS Unit will validate the TPA. After the TPA is validated, the provider must complete testing with AHCCCS prior to receiving a production 835. Testing requirements are also outlined in the Electronic Remittance Advice Manual.

Providers who have questions about this process may contact the ECS Unit at (602) 417-4706 or (602) 417-4892.

**Note:** The remaining information in this Chapter applies only the Paper Remittance Advice.

## **PAPER REMITTANCE ADVICE**

The AHCCCS paper remittance advice is broken up into two general packages or sections. The *Non-Facility Remittance Advice* section reports information related to services billed on the CMS 1500 and ADA 2002 claim forms, the *Facility Remittance Advice* section reports information related to services billed on the UB claim form. Providers may receive an Acute Remittance, a Long Term Care Remittance, a KidsCare Remittance or all three within a Remittance Advice package. The terms Acute, Long Term Care, and KidsCare designate the eligibility category of the recipients and do not refer to the type of provider.

A separate remittance is generated for claims adjudicated for recipients who receive behavioral health services through a regional behavioral health authority (RBHA) or a tribal behavioral health authority (TRBHA). This remittance is identical in format to the remittance generated for other types of recipients.

## REMITTANCE SECTIONS

Each Remittance Advice package is divided into seven sections:

- ☒ Paid claims
- ☒ Adjusted claims
- ☒ Denied claims
- ☒ Voided claims
- ☒ Claims in process
  - ✓ This section includes claims pending or reported on a previous Remittance and still in process.
- ☒ Processing Notes
  - ✓ The page provides an alphabetical listing of denial reason codes and pricing explanation codes.
  - ✓ Each is listed only once even if it applies to multiple claims.
- ☒ Grievance Process
  - ✓ This page informs providers of their grievance rights. (See [Chapter 28, Grievances](#))



## **ADDRESS PAGE AND FINANCIAL SUMMARY**

The *Address Page* of the Remittance Advice ([Exhibit 27-1](#)) displays the billing provider's name, ID and pay-to mailing address, as well as the Invoice Date and Payment Date.

The *Financial Summary* page ([Exhibit 27-2](#)) reports check and invoice data. If all claims are in process or denied, the page will indicate "No Active Invoices."

Information reported on the Financial Summary page includes:

- ☒ BILLING PROVIDER ID number plus locator codes and name
- ☒ TAX ID of the billing provider.
- ☒ PAYMENT DATE is the check date.
- ☒ PAY FOR CATEGORY.
  - ✓ Acute, Long Term Care, and KidsCare totals (as applicable) are printed on separate lines.
- ☒ CHECK NUMBER.
  - ✓ Providers receive separate checks for each Pay For Category
- ☒ INVOICE DATE is the date the invoice was submitted for payment.
- ☒ INVOICE NUMBER links payments to the services that generated the payment.
- ☒ TYPE column will indicate "CR" if the provider has a credit.
- ☒ GROSS AMOUNT is the total remitted for each Pay For Category.
  - ✓ A negative total means no payment on this remittance.
  - ✓ Gross Amount and Net Amount are usually equal unless there is a credit memo (negative invoices or recouped claims).
- ☒ DISCOUNT is never used for AHCCCS fee-for-service providers.
- ☒ NET AMOUNT is the check amount for each Pay for Category.
  - ✓ If there are outstanding credit memos, this will show zero until enough approved claims are processed to offset the credit.

## NON-FACILITY PAID CLAIMS

The *Paid Claims* section for non-facility claims ([Exhibit 27-3](#)) displays the following data:

- ☒ INVOICE DATE is the date AHCCCS processed the claims for payment.
- ☒ BILLING PROVIDER ID number plus locator codes and name.
- ☒ SERVICE PROVIDER ID number plus locator codes and name.
- ☒ INVOICE NUMBER matches the number on the Financial Summary.
- ☒ CHECK NUMBER matches the number on the Financial Summary.
- ☒ PAYMENT DATE is the date of the reimbursement check.
- ☒ TAX ID of the billing provider.
- ☒ FORM TYPE will be 1500 or Dental.
- ☒ AHCCCS ID of the recipient.
- ☒ RECIPIENT is the ID number submitted on the claim.
- ☒ NAME of the recipient as recorded in the AHCCCS system.
- ☒ PATIENT ACCOUNT NUMBER is the number entered on the claim in the patient account number field.

The *Paid Claims* section for non-facility claims (Cont.):

- ☒ CRN is the AHCCCS Claim Reference Number that is unique to each claim and remains the same over the life of the claim.
- ☒ STATUS DATE is the most recent date the claim was adjudicated (attained “Paid” status).
- ☒ SERVICE CD/MODIFIER is the CPT/HCPCS procedure code submitted on the claim.
  - ✓ Any procedure modifier would be printed below the procedure code.
- ☒ DATES OF SERVICE displays the From and Through dates of service submitted on the claim.
  - ✓ If dates are the same, only one date is displayed.
- ☒ BILLED AMOUNT submitted on the claim.
- ☒ BILLED UNITS reflects the number of units submitted on the claim.
- ☒ ALLOWED UNITS reflects the AHCCCS allowed number of units.
- ☒ ALLOWED AMOUNT may be based on the AHCCCS capped fee, a provider specific rate, Medicare Coinsurance and Deductible, etc.



## **NON-FACILITY PAID CLAIMS (CONT.)**

- ☒ NET PAID AMOUNT is the ALLOWED AMOUNT minus any deductions.
- ☒ PRICE EXPL is the pricing explanation code.
  - ✓ Definitions are printed on the Processing Notes page.
  - ✓ An asterisk ( \* ) next to a code denotes how the ALLOWED AMOUNT was determined (e.g., MCC = Medicare Coinsurance, MAX = maximum allowed charge/capped fee, etc.).

The following summary is listed at the end of each Non-facility Paid Claims section:

- ☒ NUMBER OF CLAIMS is the total number of claims in the Paid Claims section.
- ☒ TOTAL BILLED AMOUNT for all claims in the Paid Claims section.
- ☒ TOTAL REMIT AMOUNT for all claims in the Paid Claims section.

## **NON-FACILITY DENIED CLAIMS**

The *Denied Claims* section for non-facility claims ([Exhibit 27-4](#)) displays much of the same data as the Paid Claims section.

Because no reimbursement is made to the provider, the INVOICE DATE, INVOICE NUMBER, PAYMENT DATE, and CHECK NUMBER fields are not displayed in the Denied Claims section.

The Denied Claim section adds a REASON CDS field that lists the denial reason code(s). The code definitions are printed on the Processing Notes page.

Providers should make note of the AHCCCS Claim Reference Number printed in the CRN field. This number must be referenced when the denied claim is resubmitted.

The following summary is listed at the end of each Non-facility Denied Claims section:

- ☒ NUMBER OF CLAIMS in the Denied Claims section.
- ☒ TOTAL BILLED AMOUNT for all claims in the Denied Claims section.

## NON-FACILITY ADJUSTED CLAIMS

The *Adjusted Claims* section for non-facility claims ([Exhibit 27-5](#)) displays much of the same data as the Paid Claims section.

The Adjusted Claims section adds a PREVIOUSLY PAID field that displays the previously paid amount as a negative number. The NET PAID AMOUNT is the difference between the new ALLOWED AMOUNT and the PREVIOUSLY PAID amount. The net paid amount could be negative if the adjusted Allowed Amount is less than the original Allowed Amount.

The AHCCCS Claim Reference Number displayed in the CRN field is the CRN of the original claim. The claim retains this number regardless of the number of times it is adjusted.

The following summary is listed at the end of each Non-facility Adjusted Claims section:

- ☒ NUMBER OF CLAIMS is the total number of claims in the Adjusted Claims section.
- ☒ TOTAL BILLED AMOUNT for all claims in the Adjusted Claims section.
- ☒ TOTAL REMIT AMOUNT for all claims in the Adjusted Claims section.

## NON-FACILITY VOIDED CLAIMS

The *Voided Claims* section for non-facility claims ([Exhibit 27-6](#)) displays much of the same data as the Paid Claims section:

The Voided Claims section will only display CHECK NUMBER and PAYMENT DATE fields if the paid and adjusted claims during the payment cycle total more than the amount being recouped as voids.

The AHCCCS Claim Reference Number displayed in the CRN field is the CRN of the original claim. The claim retains this number when it is voided.

The ALLOWED AMOUNT is displayed as a negative amount, and any previous deductions are “backed out” and displayed as a positive number. The NET PAID AMOUNT is a negative number showing the amount recouped.

The following summary is listed at the end of each Non-facility Voided Claims section:

- ☒ NUMBER OF CLAIMS in the Voided Claims section.
- ☒ TOTAL BILLED AMOUNT for all claims in the Voided Claims section.
- ☒ TOTAL RECOUPED AMOUNT for all claims in the Voided Claims section.





## **NON-FACILITY CLAIMS IN PROCESS**

The *Claims in Process* section ([Exhibit 27-7](#)) of the Remittance Advice for non-facility claims displays all claims that have not been adjudicated. The Claims in Process section displays much of the same data described previously.

The Claims in Process section does not display any payment or edit information because the claims have not been adjudicated.

Inquiries about a claim in process should reference the AHCCCS Claim Reference Number of the claim displayed in the CRN field.

The following summary is listed at the end of each Non-facility Claims in Process section:

- ☒ NUMBER OF CLAIMS is the total number of claims in process.
- ☒ TOTAL BILLED AMOUNT for all claims in process.

## **NON-FACILITY CLAIMS PROCESSING NOTES**

The *Processing Notes* ([Exhibit 27-8](#)) section displays the following data:

- ☒ BILLING PROVIDER ID number plus locator codes and name.
- ☒ NOTE is an alphabetical listing of processing codes (denial or void reason codes, pricing method codes, etc.).
  - ✓ Each code is listed only once even if applicable to multiple claims.
- ☒ TYPE lists the type of code.
  - M = Pricing Method
  - P = Pricing Type
  - R = Reason Code
  - T = Tier
  - X = Modifier
- ☒ DESCRIPTION is the description of a processing note code.

Example:

H199.4 R CLAIM RECEIVED PAST 6 MONTH LIMIT

## **FACILITY PAID CLAIMS/INPATIENT**

The *Paid Claims* section for inpatient facility claims ([Exhibit 27-9](#)) displays much of the same data displayed in the Paid Claims section for non-facility claims.

- ☒ The FORM TYPE will be Inpatient (includes inpatient hospital and nursing home).
- ☒ The PRICE EXPL field will display:
  - ✓ For hospital inpatient claims, tier(s) into which the claim was classified are displayed (e.g., MAT = Maternity tier).
  - ✓ For hospital claims, discount and penalty percentages also are displayed.
  - ✓ For nursing home claims, codes may indicate PDM (per diem) or MCC (Medicare Coinsurance).
- ☒ TIER DATA displays the inpatient tier classification(s), number of accommodation days billed, AHCCCS allowed days for tier(s), and reason codes for any disallowed and cutback days.
- ☒ BILLED UNITS reflects accommodation days for inpatient claims.
- ☒ ALLOWED UNITS reflects accommodation days for inpatient claims.

The following summary is at the end of each Paid Claims section:

- ☒ NUMBER OF CLAIMS, both inpatient and outpatient, in the section.
- ☒ TOTAL BILLED AMOUNT for all claims in the section.
- ☒ TOTAL REMIT AMOUNT for all claims in the section.

## FACILITY PAID CLAIMS/OUTPATIENT

The *Paid Claims* section for outpatient facility claims ([Exhibit 27-10](#)) displays much of the same data displayed in the Paid Claims section for non-facility claims.

- ☒ The FORM TYPE will be Outpatient (includes outpatient hospital, dialysis facilities, hospice, and birthing centers).

## FACILITY PAID CLAIMS/OUTPATIENT (CONT.)



- ☒ The PRICE EXPL field will display:
  - ✓ For hospital outpatient claims with dates of service prior to 7/1/2005 the facility's cost to charge ratio (CCO) is displayed, for claims with dates of service on or after 7/1/2005 the O/P fee schedule amount or default Cost to Charge Ratio applied to each claim line is displayed.
  - ✓ For hospital claims, discount and penalty percentages also are displayed at the claim level.
  - ✓ Definitions are printed on the Processing Notes page.
- ☒ BILLED UNITS reflects actual line billed units for each revenue code line for outpatient claims with dates of service on or after 7/1/2005. This field is not populated for outpatient UB claims with dates of service prior to 7/1/2005.
- ☒ ALLOWED UNITS reflects actual line allowed units for outpatient claims with dates of service on or after 7/1/2005. This field is not populated for outpatient UB claims with dates of service prior to 7/1/2005.

## **FACILITY DENIED CLAIMS**

The *Denied Claims* section for facility claims ([Exhibit 27-11](#)) displays much of the same data as the Paid Claims section.

Because no reimbursement is made to the provider, the INVOICE DATE, INVOICE NUMBER, PAYMENT DATE, and CHECK NUMBER fields are not displayed in the Denied Claims section.

The REASON CDS field lists the denial reason code(s). The code definitions are printed on the Processing Notes page.

Providers should make note of the AHCCCS Claim Reference Number printed in the CRN field. This number must be referenced when the denied claim is resubmitted.

The following summary is listed at the end of each Denied Claims section:

- ☒ NUMBER OF CLAIMS in the Denied Claims section.
- ☒ TOTAL BILLED AMOUNT for all claims in the Denied Claims section.

## **FACILITY ADJUSTED CLAIMS**

The *Adjusted Claims* section for facility claims ([Exhibit 27-12](#)) displays much of the same data as the Paid Claims section:

The PREVIOUSLY PAID field displays the previously paid amount as a negative number. The NET PAID AMOUNT is the difference between the new ALLOWED AMOUNT and the PREVIOUSLY PAID amount. The net paid amount could be negative if the adjusted Allowed Amount is less than the original Allowed Amount.

The AHCCCS Claim Reference Number displayed in the CRN field is the CRN of the original claim. The claim retains this number regardless of the number of times it is adjusted.

The following summary is listed at the end of the Adjusted Claims section:

- ☒ NUMBER OF CLAIMS, both inpatient and outpatient, in the section.
- ☒ TOTAL BILLED AMOUNT for all claims in the section.
- ☒ TOTAL REMIT AMOUNT for all claims in the section.

## FACILITY VOIDED CLAIMS

The *Voided Claims* section for non-facility claims ([Exhibit 27-13](#)) displays much of the same data as the Paid Claims section:

The Voided Claims section will only display CHECK NUMBER and PAYMENT DATE fields if the paid and adjusted claims during the payment cycle total more than amount being recouped as voids.

The AHCCCS Claim Reference Number displayed in the CRN field is the CRN of the original claim. The claim retains this number when it is voided.

The ALLOWED AMOUNT is displayed as a negative amount, and any previous deductions are “backed out” and displayed as a positive number. The NET PAID AMOUNT is a negative number showing the amount recouped.

The following summary is listed at the end of each Voided Claims section:

- ☒ NUMBER OF CLAIMS, both inpatient and outpatient, in the section.
- ☒ TOTAL BILLED AMOUNT for all claims in the section.
- ☒ TOTAL RECOUPED AMOUNT for all claims in the section.

## FACILITY CLAIMS IN PROCESS

The *Claims in Process* section ([Exhibit 27-14](#)) of the Remittance Advice for facility claims displays all claims that have not been adjudicated. The Claims in Process section displays much of the same data described previously:



The Claims in Process section does not display any payment or edit information because the claims have not been adjudicated.

Inquiries about a claim in process should reference the AHCCCS Claim Reference Number of the claim displayed in the CRN field.

The following summary is listed at the end of the Claims in Process section:

- ☒ NUMBER OF CLAIMS, both inpatient and outpatient, in process.
- ☒ TOTAL BILLED AMOUNT for all claims in process.

## **FACILITY CLAIMS PROCESSING NOTES**

The *Processing Notes* section for both Acute and Long Term Care claims displays the same type of information as does the Processing Notes section for non-facility claims ([Exhibit 27-8](#)).

## **WORKING THE REMITTANCE ADVICE**

Here are some suggestions for working the AHCCCS Remittance Advice to reconcile claims billed to the AHCCCS Administration and the status of those claims:

1. Review the Paid Claims section of the Remittance Advice to determine which claims have been paid and if those claims are paid correctly. Any errors, such as claims that have not paid the correct number of units, should be marked for resubmission, noting associated CRNs. (See Chapter 4, General Billing Rules, for information on resubmitting a paid claim.)
2. Review the Adjusted Claims section of the Remittance Advice. This section will report any claims submitted by the provider as adjustments because they were not paid correctly. If problems still exist with a claim, it may be submitted again. This section also will report any claims that were adjusted by AHCCCS as a result of an audit or review.
3. Review the Voided Claims section of the Remittance Advice. This section will report any claims submitted by the provider as void transactions. There are many reasons a claim may be voided. These may be claims that have been paid by other insurance and now need to be voided so that AHCCCS can recoup its payment. This section also will report any claims that were

## **WORKING THE REMITTANCE ADVICE (CONT.)**

voided by AHCCCS as a result of an audit or medical review recoupment. Providers who believe that a claim was voided in error should contact the AHCCCS Claims Customer Service Unit.

4. Review the Denied Claims section of the Remittance Advice. Review each denial reason and determine the action necessary to correct the claim. (See [Chapter 4, General Billing Rules](#), for information on resubmitting a denied claim.)

Providers who have questions about the Remittance Advice or about resubmitting, adjusting, or voiding a claim should contact the AHCCCS Claims Customer Service Unit:

(602) 417-7670 (Phoenix Area)

(800) 794-6862 (In state)

(800) 523-0231 (Out of state)